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Adduction at the  
Hip Joint.

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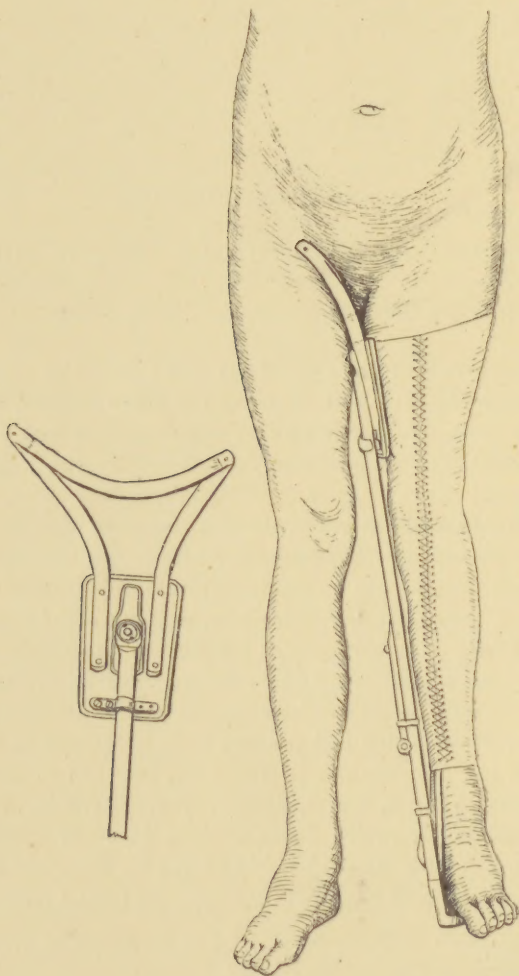
ADDUCTION of the thigh from reflex muscular spasm in the acute or progressive stages of hip disease readily yields to the protective traction which is indicated at that period, and which can be adequately furnished by the long hip-splint.

Persistent adduction in the late stages, or after the cure of the disease, whether from the neglect of proper mechanical treatment in the beginning, from a subluxation of the head of the femur due to erosions, or from other causes, is very common, very serious as regards the patient's comfort and power of easy locomotion, and often very intractable.

To overcome such deformities, as well as those where a persistent adduction had resulted from unreduced luxations of the hip, old fractures of the neck, etc., and to maintain a correct position, Dr. C. Fayette Taylor devised, and has used for about twelve years, various forms of apparatus, which exerted a direct abducting force by means of a carefully fitted crutch bearing in the opposite ischial fold. This

\* Apparatus shown at the meeting of the American Orthopædic Association, New York, June 16, 1887.

abducting arm or crutch was jointed to the knee-plate of a stiff or jointed apparatus, and was operated by a key and





ratchet, or as a toggle-joint. These devices, being found vastly more efficient, superseded entirely the *abduction screw*, and proved very satisfactory.

About three years ago Dr. C. Fayette Taylor adopted the plan of using his long hip-splint on the inside of the adducted leg and bearing above in the opposite ischial region, thereby securing great force and directness of action.

We have used this plan in appropriate cases ever since, with very great satisfaction.

The apparatus consists in the shank and side-plate of the long hip-splint which we use, ending above in properly shaped spreading bars carrying a perineal strap adjusted to the groin opposite to the adducted thigh, as shown in the cut, which also gives the detail of the upper part, viewed from the left side.

The apparatus is applied to the inside of the adducted limb, and fastened by a strap and buckles to adhesive plasters attached to the leg, as in cases of hip disease.

Screwing out the apparatus by the key produces a direct and well-nigh irresistible abducting force, which is easily borne and perfectly under control.

This apparatus is to be worn in bed, with the leg in a sling and extra weight attached; a few days to a few weeks are enough to overcome the adduction even in obstinate cases.

When the leg is sufficiently abducted, a retaining apparatus with abduction crutch, jointed to the knee-plate, is to be worn, when necessary, to maintain the correct position. We could relate a considerable number of cases, but one will suffice to illustrate the practical value of the procedure.

A gentleman reported with an adduction of the right leg of thirty years' standing, from an injury to the hip.

When seen the adduction amounted to about  $20^{\circ}$ , and could not be diminished by manual force; together with the actual

shortening it necessitated an extra sole three inches and three quarters in thickness.

The adduction was completely overcome in less than two weeks, the legs restored to vertical parallelism, and the sole reduced to one inch and three quarters, which represented the actual shortening. Progression was rendered very much easier, and the patient did not complain of pain or fatigue as he had done. The position was easily maintained by a retaining apparatus.

In this case the deformity was reduced by a less perfect apparatus than the one shown.

With these improved methods the distressing and disabling deformity of crural adduction has ceased to be, in the large majority of cases, the formidable matter that it has been, and we believe that where proper attention can be secured permanent adduction need never occur, and that when this condition has supervened it can be safely and quickly removed with scarcely any discomfort to the patient, and without resort to the knife in nearly all conditions except bony ankylosis.

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